



SUBSTANCE ABUSE PREVENTION AND CONTROL Incident Reporting Form

SUBMIT INCIDENT REPORTING FORM TO: Website: http://publichealth.lacounty.gov/sapc/

Fax: (XXX) XXX-XXXX

PATIENT INFORMATION						
1. Name (Last, First, and Middle):		Pate of Birth (MM/DD/YY):	3. Medi-Cal Number:			
4. Address:			5. Phone Number:			
6. Gender:	7. Preferred Language	8. Race/Ethnicity (Optional	Okay to Leave a Message?			
			☐ Yes ☐ No			
9. A brief description of the patient's current condition including diagnosis(es), level of care, and any other pertinent information.						
PROVIDER AGENCY WHERE INCIDENT OCCURRED						
		Contact Person:	12. Phone Number:			
13. Address:		14.Contact Person/Agency Email Address:				
15. Date of Incident (MM/DD/YY):		16. Time of Incident:				
17. Clinical Incident Type: (Check all that a	pply)	1				
2) per (energy and make	rr 47					
☐ Death – Other Than Suspected/ Known Medical Cause		☐ Client Injured another C	☐ Client Injured another Client			
	Tedical Caase	= enem injured unionier e	lient			
☐ Death – Suspected/Known Medical Caus		☐ Client Injured Staff, Vis				
☐ Death – Suspected/Known Medical Caus		-	itor, or Others			
☐ Death – Suspected/Known Medical Cause☐ Death – Suspected Suicide	se	☐ Client Injured Staff, Vis☐ Medication Error/Medic	itor, or Others ation Event			
 □ Death – Suspected/Known Medical Cause □ Death – Suspected Suicide □ Suicide Attempt Requiring Emergency Toldands 	reatment (EMT)	□ Client Injured Staff, Vis□ Medication Error/Medic□ Alleged Client Abused I	itor, or Others ation Event By Staff			
 □ Death – Suspected/Known Medical Cause □ Death – Suspected Suicide □ Suicide Attempt Requiring Emergency T □ Client Injured Self (Not Suicide Attempt 	reatment (EMT)	 □ Client Injured Staff, Vis □ Medication Error/Medic □ Alleged Client Abused I □ Possibility or Threat of I 	itor, or Others ation Event By Staff Legal Action			
 □ Death – Suspected/Known Medical Cause □ Death – Suspected Suicide □ Suicide Attempt Requiring Emergency Toldands 	reatment (EMT)	 □ Client Injured Staff, Vis □ Medication Error/Medic □ Alleged Client Abused I □ Possibility or Threat of I 	itor, or Others ation Event By Staff			
 □ Death – Suspected/Known Medical Cause □ Death – Suspected Suicide □ Suicide Attempt Requiring Emergency T □ Client Injured Self (Not Suicide Attempt 	reatment (EMT)	 □ Client Injured Staff, Vis □ Medication Error/Medic □ Alleged Client Abused I □ Possibility or Threat of I 	itor, or Others ation Event By Staff Legal Action			

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code, HIPAA Privacy Standards, and 42 CFR Part 2. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

DESCRIPTION OF THE INCIDENT					
18. Please describe the nature of the incadditional sheets, if needed.	ident. Include any important information	about the incident, such as the date, per-	son(s) involved, witnesses, etc. Attach		
19. List any pre-disposing factor(s) or r	oot cause(s) relevant to this incident:				
	DECDONCE AND EO				
20 74	RESPONSE AND FO				
20. Please describe the staff response to needed.	o the incident. Include description of inte	rvention(s) applied when dealing with th	e incident. Attach additional sneets, if		
21. List any case reviews, trainings, changes to policies and procedures, or follow up by the Risk Management Committee that were performed or instituted in order to prevent similar events in the future.					
22 P G. CON	22 M N	0	1 05 D		
22. Reporting Staff Name:	23. Manager Name:	24. Manager Signature:	25. Date:		
	INTERNAL SA	PC USE ONLV			
☐ Reportable Incident (Logged)	☐ Adverse Event (Logged)	☐ Issue of Concern (Logged)	☐ No Further Action Needed		
	= 1.01.01.0 2.1011 (205gett)	_ 1544 of Conton (20gg-0)	_ 1014440.1040110000		
Comments:					
Reviewed by:	Signature:	Date:			

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Client Name: _____Medi-Cal ID: _____
Treatment Agency: _____

CLINICAL INCIDENT FORM INSTRUCTIONS

PATIENT INFORMATION

- 1. Enter the patient's name in the order of last name, first name, and middle name.
- 2. Enter the patient's date of birth.
- 3. Enter the patient's Medi-Cal number. If the number is not known, leave the space blank.
- 4. Enter the patient's address.
- 5. Enter the patient's phone number. Check box to indicate if it is okay to leave a message at this phone number.
- 6. Enter the patient's gender.
- 7. Enter the patient's preferred language.
- 8. Enter the patient's race/ethnicity (optional).
- 9. Enter a brief description of the patient's current condition including diagnosis(es), level of care, and any other pertinent information.

PROVIDER AGENCY WHERE INCIDENT OCCURRED

- 10. Enter the provider agency's name.
- 11. Enter the name of the provider agency's contact person.
- 12. Enter the contact person's phone number.
- 13. Enter the provider agency's address.
- 14. Enter the provider agency's or the contact person's email address.
- 15. Enter the date of incident.
- 16. Enter the time of incident.
- 17. Clinical incident type: (check all that apply).
- 18. Please describe the nature of the incident. Include any important information about the incident, such as the date, person(s) involved, names of the witnesses, etc. Attach additional sheets, if needed.
- 19. List any pre-disposing factor(s) or root cause(s) relevant to this incident.

INCIDENT RESPONSE AND FOLLOW UP ACTION

- 20. Please describe the staff response to the incident. Include description of intervention(s) applied to when dealing with the incident. Attach additional sheets, if needed.
- 21. List any case reviews, trainings, changes to policies and procedures, or follow up by the Risk Management Committee that were performed or instituted in order to prevent similar events in the future.
- 22. Enter the name of the reporting staff.
- 23. Enter the name of the manager.
- 24. Enter the signature of manager.
- 25. Enter the date the manager signed the report.

INTERNAL SAPC USE ONLY

This section reserved for internal SAPC use only.

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